

IRO America Inc.

An Independent Review Organization

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Amended October 5, 2006

August 9, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

IRO #:

M5-06-1700-01

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including but not limited to: Medical records from Requestor, Respondent, Treating Doctor, Insurance Company, including but not limited to IRO request, 7-pages MDR Request/Response; 4-pages denied EOBs; 2-pages Carrier's statement; 2-pages Transcription dated 3-1-04; 2-pages MRI lumbar spine dated 5-7-04; Progress notes dated 2-21-05, 6-22-05, 7-18-05, 7-25-05; Operative report dated 3-22-05; TWCC-69; 2-pages Report of Medical Evaluation dated 10-27-05; 4-pages Review of Medical Records dated 10-27-05; Follow-up Evaluation dated 7-7-05, 6-20-05; 8-pages Independent Medical Evaluation report dated 9-13-05

CLINICAL HISTORY

The Patient sustained a work related injury on _____. The Patient apparently was working for _____, when he injured his low back. He was driving a forklift when he slipped and fell and injured his low back. He was referred to the company doctors, where he was prescribed medication and started therapy. On 5-7-2004, he underwent an MRI of the lumbar spine, which revealed a L5-S1 right disc herniation indenting the thecal sac and exiting nerve root and a L4-5 right disc herniation. The Patient underwent injections x2 by Dr. Kramer. On 2-14-2005, he had a Myelogram with pre/post CT scan, which revealed underfilling of both S1 nerve root sleeves and underfilling of the right L5 nerve root sleeve. On 3-22-2005, the Patient eventually underwent a lumbar laminectomy, foraminotomy and wide decompression of the L5-S1 on the right and discectomy at L5-S1 on the right. He continued with post operative therapy through 6-24-2005 to 7-29-2005.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of AQUATIC THERAPY-97113, ELECTRICAL STIMULATION-97032, and MANUAL THERAPY-97140 for the dates 6/24/05 through 7/29/05.

DETERMINATION/DECISION

The reviewer partially agrees with the determination of the insurance carrier. AQUATIC THERAPY-97113 (3-units) were medically necessary and that 6-units would not be medically necessary for the dates 6/24/2005 through 7/29/2005.

The reviewer disagrees with the insurance carrier in that the ELECTRICAL STIMULATION-97032 (1-unit), and MANUAL THERAPY-97140 (1-unit) for the dates 6/24/2005 through 7/29/2005 were medically necessary.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer's medical assessment is that the disputed services: AQUATIC THERAPY-97113, ELECTRICAL STIMULATION-97032, and MANUAL THERAPY-97140 for DATES OF SERVICE 6-24-2005 THROUGH 7-29-2005 were medically necessary as described above. The Patient eventually underwent a lumbar laminectomy, foraminotomy and wide decompression of the L5-S1 on the right and discectomy at L5-S1 on the right on 3-22-2005 and post-operative passive therapy. IME was performed on 9-13-2005 with Dr. George, who recommended that the Patient would not require additional treatment and would only require a home exercise program.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for

presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,

IRO America Inc.



Dr. Roger Glenn Brown

President & Chief Resolutions Officer

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 9th day of August, 2006.

Name and Signature of IRO America Representative:

Sincerely,

IRO America Inc.

A handwritten signature in black ink, appearing to read "Dr. Roger Glenn Brown", with a long horizontal flourish extending to the right.

Dr. Roger Glenn Brown

President & Chief Resolutions Officer